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N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH		ARIZONA STATE BOARD OF HEALTH	
BUREAU OF VITAL STATISTICS		ORIGINAL CERTIFICATE OF DEATH	
1. County <u>Cochise</u>	State Index - - No. <u>78</u>	County Registrar's No. <u>652</u>	
District <u>Ft. Huachuca</u>	Local Registrar's - No. <u>11</u>		
Town or City	No. _____ St. _____ Ward _____	(If death occurred in a hospital or institution, give its NAME instead of street and number)	
2. FULL NAME <u>Robert Chenault</u>			
(a) Residence. No. _____ St. _____ Ward _____		(If nonresident, give city or town and State)	
(Usual place of abode)			
Length of residence in city or town where death occurred yrs. mos. ds.		How long in U. S., if of foreign birth? yrs. mos. ds.	
PERSONAL AND STATISTICAL PARTICULARS			
3. SEX <u>Male</u>	4. COLOR or RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED or DIVORCED (write the word) <u>Single</u>	
5a. If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____			
6. DATE OF BIRTH (month, day and year)			
7. AGE <u>44</u>	Years	Months	Days
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IF LESS than 1 day...hrs. or...min.			
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Soldier</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer			
9. BIRTHPLACE (city or town) <u>Kentucky</u> (State or country)			
10. NAME OF FATHER <u>Unknown</u>			
11. BIRTHPLACE OF FATHER (city or town) (State or country) <u>Unknown</u>			
12. MAIDEN NAME OF MOTHER <u>Unknown</u>			
13. BIRTHPLACE OF MOTHER (city or town) <u>Unknown</u> (State or country)			
14. Informant (Address)			
15. Filed <u>Mar 30, 1922</u> V. S. No. 1 <u>4-7-22</u> <u>J. C. Johnson</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16. DATE OF DEATH (month, day, and year) <u>Mar 27/22</u>			
17. I HEREBY CERTIFY, That I attended deceased from <u>January 30, 1922</u> to <u>March 27 1922</u> , 19____, that I last saw him alive on <u>March 26, 1922</u> , 19____, and that death occurred, on the date stated above, at <u>1:12 a.</u> m. The CAUSE OF DEATH* was as follows: <u>Apoplexy</u>			
18. Where was disease contracted If not at place of death?			
Did an operation precede death? _____ Date of _____			
Was there an autopsy? <u>NO</u>			
What test confirmed diagnosis? (Signed) <u>John R. Johnson</u> Capt. MC, M. D. 19 (Address) <u>Ft. Huachuca, Ariz.</u>			
* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)			
19. PLACE OF BURIAL, CREMATION OR REMOVAL		DATE OF BURIAL	
20. UNDERTAKER		ADDRESS	